



**AAMC President's Address 2009:
"The Innovation Imperative"**

AAMC President and CEO Darrell G. Kirch, M.D., delivered the following address at the association's 120th Annual Meeting in Boston on November 8, 2009:

"Last year, we met in San Antonio on the eve of an extraordinary election with an incredible sense of national hope gaining momentum. While at the time we knew the country faced major challenges, I am not certain any of us could have predicted the highs and lows of the year ahead. We began 2009 with the promise of a new administration, but also with our retirement savings dwindling and millions of Americans out of work. A month later, we saw a massive economic recovery package that brought over \$10 billion in new, two-year funding to the National Institutes of Health (NIH). However, we still face the struggle to ensure sustainable, predictable NIH funding when that stimulus ends. In terms of building our physician workforce, this year many of our member schools expanded their classes and four new medical schools opened their doors, yet we still face an uphill battle to expand the number of federally supported residency positions. Meeting our AAMC mission to 'serve and lead the academic medicine community to improve the health of all' seems more challenging than ever.

In one of his early messages to the country, President Obama made it clear that he and his advisers viewed the high cost and long-term financial unsustainability of our health care system as occupying a pivotal role in our financial crisis. There appeared to be growing agreement that American citizens and American businesses could no longer

afford the rapidly escalating costs of health care. Even more important, we finally seemed to have a growing sense of national shame that more than 46 million American citizens had no health insurance whatsoever. In the quest to return to economic solid ground and to rescue our fellow citizens left out in the uninsured cold, fixing our health care system became a top national priority. Collectively, we seemed ready to do something that had eluded our country for decades: early this year Congress began to draft bills to make health care reform actually happen!

But by the time August arrived, and I began thinking about my annual meeting address, something was taking place in our country that was truly painful to observe. The usually quiet congressional summer recess, because of town hall meetings nationwide, was marked by some of the most rancorous debate we have ever experienced. It was as if all the fears Americans have had about government since the days when King George III ruled and Bostonians down the street were dumping tea in the harbor suddenly resurfaced.

Just a few months earlier, it appeared as if the majority of Americans believed that, 'Yes we can!' and there was a pervasive sense of hope. By late summer, however, it seemed as if too many of our fellow citizens were responding to the health care debate by saying, 'No we can't.' We saw some of our neighbors slide down the slope of anti-government paranoia, saying, 'Stop the death panels—don't euthanize Grandma!' To add an element of absurdity, some government beneficiaries were stridently demanding that Congress 'keep the government's hand off my Medicare!'

In early September, President Obama—in an attempt to bring the nation back to some modicum of reasonable discussion—requested a special joint session of Congress to deliver a national primetime speech. I would imagine that many of our members watched that speech, anxiously looking for signs of hope that we could get out of the deeply partisan morass in which we again seemed to be embedded. But even in the hallowed halls of Congress, and on national television, an angry representative shouted an insult directly at our president, showing just how deeply—and sometimes bitterly—divided our nation remained.

But the work continued, and as we meet today, there is every indication that a House and Senate health care reform bill is likely to be forged in the next several weeks and ultimately signed by the President. I know that virtually all of our members believe that providing health insurance to more people is a good thing; many even see it as a moral imperative. One of academic medicine's greatest champions and a Massachusetts favorite son, the late Senator Ted Kennedy, made it his life's work. Legislation being debated holds the promise of providing health insurance coverage to a clear majority of Americans, bringing us closer to Senator Kennedy's goal.

Therefore, on one hand, the nation may be on the verge of finally addressing a longstanding issue of social justice by legislating greater health insurance coverage. On the other, this news must be tempered with the realization that meaningful change and comprehensive reform of our nation's health care will not occur until we transform how we actually deliver it. The hardest work is still ahead. And so, while we should celebrate the passage of legislation to improve health insurance coverage, we should not think that our larger health system problems have been solved.

This is where academic medicine meets the ‘innovation imperative.’

A word of warning is in order. Innovation in health care is not for the faint-hearted! The transformational change required to correct the dysfunctions in our health care system will take extraordinary creativity. It also will require the courage to confront our own inertia and powerful vested interests. In addition, we will need research to study our results as well as new approaches to create the physician workforce for the health care system that evolves.

As a nation, we were built on innovation. It is particularly fitting that our 120th Annual Meeting is in Boston—a city so steeped in history that, everywhere you turn, there are reminders of one of the most remarkable innovations of all: the American system of government. Some of the most impassioned meetings about our political system and speeches by some of our greatest leaders took place not far from the Hynes Convention Center, at Faneuil Hall, where George Washington toasted our nation’s first birthday. Despite its flaws, our ongoing ‘experiment in democracy’ is unmatched by that of any other nation in the world.

Throughout our country’s history, we have often looked to the states as sources of innovation. Here in Massachusetts, the bold step was taken to bring health insurance to as many citizens as possible. With that step, however, the Commonwealth also demonstrated the complexity of health care innovation, revealing far too few primary care providers to meet the demand of the newly insured. Now, as a result of the Massachusetts experiment, it is very clear that, even when a final health insurance expansion bill passes this Congress, much work remains.

What we call a ‘health care system’ in America is, in most cases, a loose collection of independent facilities and providers. Even worse, all too often each entity is focused on maximizing its own volume of care in line with the powerful incentives of fee-for-service reimbursement. Health care in America today consists of well-trained, well-intentioned providers, virtually all of whom have become dependent upon performing as many visits—and especially on performing as many tests and procedures—as they can. Volume and interventions are rewarded; few physicians are paid if patients are healthy.

You may be familiar with Clayton Christensen—who spoke at the AAMC Annual Meeting five years ago—and his growing body of work on ‘disruptive innovation.’ According to Christensen, disruptive innovation transforms a given industry from one where its products or services are expensive and complex to one where those products or services become more widely available and, at the same time, improved in quality and/or cost. In his latest book, *The Innovator’s Prescription: A Disruptive Solution for Health Care*, Christensen devotes an entire chapter to potential disruptive innovations in medical education.

The fragmentation, quality deficiencies, and high costs within our overall health care system make it a prime candidate for the kind of disruptive innovation Christensen describes. In fact, many policymakers and leaders in academic medicine are advocating for this kind of disruption. They present a strong case for retooling the business model of health care from paying for units of service to paying for outcomes. As compelling as that sounds, these discussions, unfortunately, remain largely at the conceptual stage. As a nation, we are waiting for the real world innovation that will finally close the gap between the theory of this better system and its actual practice.

The question is not whether that innovative disruption will happen, but rather who will lead it. The AAMC has developed an idea about how academic medicine can accept the innovation imperative and lead this transformation—an idea to which I will return shortly.

As Steve Jobs, co-founder and CEO of Apple, once observed, ‘Innovation distinguishes between a leader and a follower.’ I believe the individuals at our member medical schools and teaching hospitals are the true leaders. Since becoming AAMC president, I continually have been impressed by our members’ innovative spirit and willingness to move toward a new health care culture—one that is patient-centered, quality and outcomes-focused, team-based, and highly collaborative. In fact, the rate of innovation among our institutions often outpaces our ability to document, much less publicize, the degree of transformation under way, and that innovation is taking place in each of our mission areas of patient care, research, and education.

Some of our critics would say that academic medical centers are the least likely source of the much-needed innovation in health care. They talk about our expert-centrism and traditional departmental ‘silos.’ They point to our general resistance to change and slow decision-making processes. But that is the old culture I see so many of our institutions working tirelessly to change. Our members at academic medical centers across the country already are demonstrating remarkable clinical innovation by designing new models of care delivery. They are finding models that not only promote health and wellness, but that also are more affordable—models that give us true value. This gives me real hope!

True to our tripartite mission, that same spirit of innovation our members are showing in clinical care is also taking place in research and education.

In research—as the scientific world becomes increasingly focused on collaboration between individuals and groups to solve complex problems—institutions that are part of the Clinical and Translational Science Award consortium have emerged as powerful role models for the larger academic medicine community. Even while struggling for adequate funding, these institutions have illustrated the power of connecting the laboratory bench to the community in ways that R01 grants—while important to fundamental discovery—were not able to help us do.

In medical education, we have left a time in which each faculty member owned his or her own lecture—all too often using outdated 35 mm slides—and now operate in a Web-based, interactive world. Today, much of the disruptive innovation in medical education takes the form of cutting-edge technology to teach and assess our learners. We use tools ranging from our own AAMC MedEdPORTAL®; to high-tech simulators right outside the operating room; to creating lifelong, Web-based e-Portfolios to assess competence.

Given this, what lies ahead? If we assume that Congress passes and the president signs a bill that gives more Americans health insurance, can academic medicine take the lead in accomplishing the work that remains? I would argue that it is the academic medicine community—teachers, researchers, clinicians, as well as students and trainees—who should respond to this imperative and be the standard bearers for innovation in health care delivery. We are the people who should conduct the new

science of health care reform to show what truly works and who should create the kind of health professional needed in this new system.

The reason I see our community as a natural leader of this innovation involves the unique nature of our organizations. Most scholars agree that the health care system we need will demand a level of integration of doctors and hospitals that does not widely exist in our nation. However, it *does* exist in most academic medical centers, and many members work hard to strengthen this internal integration and to improve quality and reduce costs. Among the features of the high-performance, high-value, integrated health systems some of our members already have established are: coordinating care for the chronically ill, more wisely monitoring the use of tests and interventions, and rewarding providers for outcomes rather than volume.

Beyond redesigning care, we will need focused research investments and trained investigators to perform comparative effectiveness studies on these new delivery models to see what does and what does not work to improve the health of the community, as well as how we can finally 'bend the curve' of rising costs. Just as important, we will need to determine the right number and mix of health professionals for this new environment. Perhaps an even greater challenge for the academic medical center will be to transform the way students are educated. We will need to go beyond redesigning our care system to actually teaching medical students, residents, and other health professionals to work as teams and to develop the new skills for such a system.

Combining innovations in health care delivery, critically studying the effectiveness of these innovations, and educating professionals to work in these new models play to the

strengths of academic medicine. The innovation imperative will allow academic medical centers to finally attain alignment of all three missions, while truly fulfilling their goal to improve the health of communities.

Thanks to the efforts of both my AAMC colleagues and key leaders from our members, we soon may have a new tool to help us lead this innovation. When it became clear that health care legislation would be focused almost exclusively on expanding health insurance, I was privileged to attend a White House meeting in March in which we introduced the idea of advancing broader health system change by creating federal 'Healthcare Innovation Zones,' or HIZs. We have devoted the last several months to working with Congress to draft legislation to put academic medical centers in a position to advance further health care transformation.

The proposed legislation would empower academic medical centers and partners in their community to conduct large-scale experiments in innovative approaches to health care delivery for specific patient populations. In our White House meeting, we described how an academic medical center (if it is ready and willing to create an HIZ) would be the place in which its integrated system, together with other willing partnering hospitals and providers, could demonstrate new models of care, closely supported by collaborating researchers and educators. Creating an HIZ could facilitate rapid expansion of the kind of pioneering efforts already under way at our institutions. By using special planning grants, combining varied federal payment waivers, and allowing certain forms of deregulation, the HIZ program would encourage more academic medical centers to embrace factors critical for success, such as promoting the value of teams, incorporating state-of-the-art technology, focusing on quality improvement, and

connecting to communities. By responding to the innovation imperative, these academic centers could become the leaders in true health care reform. I feel confident that legislation enabling HIZs will be part of action taken by Congress this year.

A year ago, people asked me whether I believed that academic medicine would have any voice in the health care reform debate. We indeed have had a strong voice in ensuring that the special contributions of our members are recognized in any proposed changes in the current legislation. And now, with the likely creation by Congress of the HIZ program, we have a real opportunity to go beyond having a voice in preserving the value of our institutions to actually leading the process of true, comprehensive health care reform.

Over the last few months, it has been gratifying to see members of Congress and the administration viewing us as willing partners—rather than obstacles—to further reform. I am particularly gratified by the work of Rep. Allyson Schwartz (D-Pa.), who championed the HIZ legislation and who, with Rep. Patrick Tiberi (R-Ohio), founded the first-ever academic medicine congressional caucus. But developing the HIZ concept and finding congressional champions is only a start. As is the case with every disruptive innovation, we will need ‘early adopters’ to diffuse this process of health care transformation more in depth and to a broader audience. This is the challenge, and this is the great opportunity, for academic medical centers. Far too many people inside the Beltway think academic medicine stands in the way of a better health care system. By creating Healthcare Innovation Zones, those academic medical centers that are ready and willing will have the opportunity to prove them wrong.

But let me repeat my earlier warning. Innovation is not for the faint-hearted. All of us are very conscious of our career aspirations and of what we have been told is the prescribed path to success. That path usually involves sticking to the tried and true: teach your students, do your research, write your papers, and see your patients. We are not inclined to take risks. But risks, and even potential failure, are inherent in any attempt to innovate.

What gives me hope is the courage I have seen throughout our community. As a profession, academic medicine requires a tremendous degree of personal courage. Our members have shown the courage to posit untested hypotheses and make the unknowable, knowable. They also have shown the courage not only to teach the next generation, but also to be tested and challenged every day by their insistent questions. And they have had the courage to repeatedly highlight the basic injustice in leaving so many Americans without health care insurance. As we finally appear ready as a nation to give more Americans that protection, as a profession we are holding fast to our basic ethical commitment to social justice. Now we need to turn that same courage to tackling our cumbersome and costly 'non-system' of fragmented health care.

Next year, when we meet again in Washington, D.C., it will be the centennial year of the Flexner Report, the landmark document that, in 1910, led to revolutionary change in medical education. It took courage for Flexner to challenge the blight of proprietary storefront medical schools. And it has taken courage for academic medicine to address the many tough questions it has faced since that time. Now, we have the chance to confront the many ways our health care system fails us and lead the nation toward the

kind of health care system we all visualize and deeply desire. Showing the courage to accept the innovation imperative truly is up to us!

Thank you.”

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